South Carolina Department of Disabilities and Special Needs

Authorization for Temporary EIBI State Funded Program Services

TO BE INVOICED TO SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS

TO: _____

_____

RE: _____
Participant's Name / **Date of Birth**

_____
Address

_____
Parent Name / **Phone Number**

Service Authorization Number_____

You are hereby authorized to provide the following service(s) to the participant named above. Only the number of hours rendered may be billed.

Early Intensive Behavioral Intervention Services:

Assessment (H2000): _____
Program Development & Training (T2025): _____
Plan Implementation (H0032): _____ hours per month
EIBI Lead Therapy (G0177): _____ hours per week
EIBI Line Therapy (H0046): _____ hours per week
Start Date: _____

Case Manager: Name / Address / Phone Number / E-mail **(Please Print)**

_____

_____

_____

_____
Signature of person authorizing services **Date**

SAMPLE